CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 465 **Date: FEBRUARY 4, 2005**

CHANGE REQUEST 3559

SUBJECT: Billing Requirements for Physician Services in Method II Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: This transmittal 1) Establishes a mechanism that will prevent the overpayment of physician services rendered in a method II CAH; 2) Corrects the type of bill (TOB) for CAH outpatient to 85x (the TOB was stated as 72x in CR 3262, Transmittal 262, dated July 30, 2004); 3) Clarifies the applicability of the payment window provisions; 4) Includes the new file layout for the 2005, Physician Fee Schedule Supplemental file; and 5) Establishes a "V" in the third position of a CAH provider number to differentiate its off-site clinic/outpatient department.

NEW/REVISED MATERIAL - EFFECTIVE DATE:

HPSA bonus – January 5, 2004
Physician Scarcity – January 3, 2005
Physician Services – July 1, 2001
(Procedure for adjustments will be forwarded at a later date).

***IMPLEMENTATION DATE: July 5, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/30/.1/.1/ Payment for Inpatient Services Furnished by a CAH
R	4/250/.2 /Special Rules for Critical Access Hospital Outpatient Billing
R	4/250/2.1/Billing and Payment in a Physician Scarcity Area (PSA)

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 465	Date: February 4, 2005	Change Request 3559

SUBJECT: Billing Requirements for Physician Services in Method II Critical Access Hospitals (CAHs)

I. GENERAL INFORMATION

A. Background: The correct type of bill (TOB) for a CAH for outpatient services is 85x. In CR 3262, Transmittal 262, dated July 30, 2004, TOB 72x was stated in error.

Clarification on CAHs being exempt from the payment window provisions is included in the attached manual instructions.

Payment for some physician services submitted by CAHs utilizing method II billing is being paid incorrectly. This is occurring because intermediaries are making payments based on the supplemental file, which has contained only non-facility fee schedule amounts until now. Under method II, physician services are paid to the CAH at 115% of the applicable Medicare Physician Fee Schedule (MPFS) payment amount. Payment should be based on the MPFS facility rate for the applicable HCPCS codes. FIs have been incorrectly paying the MPFS non-facility rate, since that was the only rate they have received. This instruction includes guidelines for paying the correct MPFS facility rate.

The MMA established an additional 5 % payment for services rendered in a Physician Scarcity Area (PSA), and required the automation of the Health Professional Shortage Area (HPSA**)** incentive payment. CAHs can have clinics/outpatient departments that are off-site, not physically located in the hospital. Presently, there is no way to differentiate the offsite clinic/outpatient department bill from the CAH bill; therefore, no bonus payments are being made for services rendered in the off-site clinic/outpatient department if its location differs from that of the CAH itself. For example: 1) If a CAH is not located in a bonus area and the off-site clinic/outpatient department is located in a bonus area, the physician bonus is payable; or 2) If the CAH is in a bonus area, but the physician service is rendered at the off-site clinic/outpatient department which is not located in a bonus area, a bonus payment would be incorrect.

B. Policy: Physician services that are rendered in a CAH facility, billing under method II, should be paid using the appropriate facility fee schedule amount from the Medicare Physician Fee Schedule.

CMS has established a “V” in the third position of the provider number to identify off-site outpatient departments/clinics of CAHs.

The policy for bonus payments is consistent with instructions in CR 3262.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv

message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3559.1	The FI/FISS shall load the facility rate for each HCPCS.	X				X				
3559.2	The FI/FISS shall use the established Medicare Physician Fee Schedule (MPFS) supplemental file, to pay the professional component when appropriate.	X				X				
3559.2.1	The FI/FISS shall use the new Record Layout for the CORF Services Supplemental Fee/Schedule Critical Access Hospital Fee Schedule.	X				X				
3559.3	The FI/FISS shall pay the facility fee amount for the HCPCS code for the physician service rendered, to a CAH under the method II payment methodology.	X				X				
3559.4	The FIs shall inform their CAHs that elect Method II billing to place a "V" in the third position of their provider number when billing for their off-site clinic/outpatient department.	X				X				
3559.4.1	CWF shall accept the "V" in the third position of CAH provider number on 85x type of bill.								X	

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3559.5	The FIs shall inform their CAHs that the off-site clinic/outpatient department's address, including zip code, should be placed in the 2310E loop of the 837I for electronic claims. For billing on a hard copy UB-92 and DDE, the service address should be placed in the "Remarks." However, the zip code placement will be determined by the FI.	X				X				
3559.5.1	The FISS shall read loop 2310E of the 837I for claims containing the "V" in the third position of the CAH provider number and carry the zip code in it's claims file.					X				
3559.5.2	The FISS shall create (maximum of 3 iterations) fields in the provider file to carry the zip codes and indicators, for off-site clinic/outpatient departments					X				
3559.6	The FISS must look at the provider number and the service facility zip code to determine if a bonus payment is due for professional services.					X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Physician Services –July 1, 2001 HPSA Bonus – January 5, 2004 Physician Scarcity – January 3, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Doris Barham – 410-786-6146; Pat Barrett- 410-786-0508 **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 465, Issued: 02-04-05, Effective: 07-01-01, Implementation: 07-05-05)

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101 percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that following principles do not apply:

- The lesser of costs or charges (LCC) rule,
- Ceilings on hospital operating costs,
- The reasonable compensation equivalent (RCE) limits for physician services to hospitals and
- The payment window provisions for preadmission services treated as inpatient services under §40.3. (*Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient, are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill(85x TOB) from inpatient services. CWF and the shared system bypass the CAH provider numbers when applying the edits that compare hospital outpatient and inpatient bills to apply the window provisions. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH).*

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirements. Inpatient services should be billed on an 11X type of bill.

Payment for a cost reporting period subsequent to the initial 12-month period for which the CAH operates is made on the basis of adjusting the amount determined for the initial 12-month period. Under §1886(b)(3)(B)(i) of the Act, the adjustment added to the per diem amount is the market basket percentage increase for the subsequent cost reporting period applicable to hospitals located in rural areas.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Medicare Physician Fee Schedule Payment for Professional Services

(Rev. 465, Issued: 02-04-05, Effective: 07-01-01, Implementation: 07-05-05)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. The MMA provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The method chosen will remain in affect for that entire cost reporting period.

The CAH must have a copy of the 855I, in which the individual practitioner must certify their assignment to the CAH, from each practitioner who wishes to reassign his or her billing rights. The CAH must also have the practitioner sign an "attestation" that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment for professional services furnished in that CAH's outpatient department, from their intermediary. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner, payment will be based on 101 percent of the reasonable costs of the services. On the Form CMS-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus
- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

- Use the Medicare Physician Fee Schedule (MPFS) supplemental file, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for nonphysician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill. Referenced diagnostic services (non-patients) are billed on bill type 14X.

The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. *If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.*

CORF SERVICES SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

DATA SET NAMES: **MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI**
This is the final physician fee schedule supplemental file.

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture Value	
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	
5--Filler	17-17	X(01)	
6--PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have Elected the optional method (Method 2) of payment.
7--Filler	19	X(1)	
8--Facility Fee	20-26	9(05)V99	
9--Filler	27-30	X(4)	
10--Carrier Number	31-35	X(05)	
11--Locality	36-37	X(02)	

12--Filler	38-40	X(03)	
13—Fee Indicator	41-41	X(1)	Field not populated—filled with spaces.
14--Outpatient Hospital	42-42	X(1)	Field not populated—filled with spaces.
15--Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
14—Filler	44-60	X(17)	

If a non-physician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.**

250.2.1 Billing and Payment in a Physician Scarcity Area (PSA)

(Rev. 465, Issued: 02-04-05, Effective: 01-03-05, Implementation: 07-05-05)

Section 413a of the MMA 2003 requires that a new 5 percent bonus payment be established for physicians in designated physician scarcity areas. The payment should be made on a quarterly basis and placed on the quarterly report that is now being produced for the HPSA bonus payments.

Section 1861(r)(1), of the Act, defines physicians as doctors of medicine or osteopathy. Therefore, dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary care or specialty physicians. Only the primary care designations of General Practice, Family Practice, Internal Medicine, and Obstetrics/Gynecology, will be paid the bonus for the zip codes designated as primary care scarcity areas. All physician provider specialties are eligible for the specialty physician scarcity bonus except the following: Oral Surgery (dentist only); Chiropractic; Optometry; and Podiatry. The bonus is to be paid based on date of service.

One of the following modifier(s) must accompany the HCPCS code to indicate type of physician:

AG - Primary Physician
AF - Specialty Physician

There may be situations when a CAH is not located in a bonus area but its clinic/outpatient is in a designated bonus area, or vice versa. If a CAH has an off-site clinic/outpatient department, a "V" must be placed in the third position of the CAHs' provider number (xxVxxx) when billing for services provided in such a clinic. The clinic's complete address, including the zip code, must be placed on the claim as the service facility. The FISS must look at the provider number and the service facility zip code to determine if a bonus payment is due.

For electronic claims, the service facility address should be in the 2310E loop of the 837I. The address should be placed in "Remarks" on the hard copy UB-92.